State of Nevada
Victims of Crime Program

Employers Verification of Employment and Lost Wages

Use this form to verify applicant/employee's wage loss information when applicant is requesting lost wage reimbursement.

Employee Information:

Employee Name:	Last 4 digits SSN:	VOCP Claim #

Employer Information:

Employers Name:	Phone:	Fax:
Employers Mailing Address:	City, State, Zip:	

Employee Lost Time Information:

Did employee miss work due to his or her *crime injuries*?	If employee missed work did they return?	If employee did not return to work please indicate why:
☐ Yes ☐ No If *Yes*: Enter first date not worked:	☐ Yes ☐ No If *Yes*: Enter date returned to work:	☐ Employee is still off work due to the crime injuries. ☐ Employee no longer employed with this employer

Employee Hours and Wage Loss Information:

Number of Hours Worked:	Amount Paid: $ _____	Total amount of wages lost by employee due to crime injuries:
☐ _____ Per Day ☐ _____ Per Week ☐ _____ Per Pay Period ☐ _____ Other:	☐ _____ Hourly ☐ _____ Daily ☐ _____ Weekly ☐ _____ Other:	$ _____

Did employee receive other compensation in addition to wages stated above (tips, commissions, bonuses, etc)?
☐ Yes If *Yes,* please state average daily additional compensation: $ _____
☐ No

Employee Insurance Information:

At the time of the crime, did the employee have medical insurance coverage through the employer or a union?
☐ Yes If *Yes*, Name of insurance carrier & policy number or name and address of union:
☐ No

If Employee is deceased, were life insurance benefits paid to beneficiaries?
☐ Yes If *Yes*. Names of beneficiaries and amounts paid:
☐ No

I certify that the information provided is true and correct to the best of my information and belief.

Authorized Signature:	Print Name:	Title:
Date:	Telephone:	Email:

Mail to: VOCP P O Box 94525 Las Vegas, NV 89193-1525	*Fax to:* *(702) 458-5586*	*Scan and email to:* *applications@voc-net.com*